

1500

CARRIER

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #)            MEDICAID <input type="checkbox"/> (Medicaid #)            TRICARE <input type="checkbox"/> (Sponsor's SSN)            CHAMPVA <input type="checkbox"/> (Member ID)            GROUP <input type="checkbox"/> (SSN or ID)            FECA <input type="checkbox"/> (SSN)            OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY		STATE	
ZIP CODE		E (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
10. IS PATIENT'S CONDITION RELATED TO:			
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			

**Note:** Remember to enter all data on the claim form within the designated areas for each field. Information used to complete examples is fictitious.

**Note:** After typing data in a field, press **Enter** to continue to the next field.

**Continue with activity**

Click to print the field data to complete this activity.

**Note:** After typing data in a field, press **Enter** to continue to the next field.

**Note:** Remember to enter all data on the claim form within the designated areas for each field. Information used to complete examples is fictitious.

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HEALTH INSURANCE CLAIM FORM														
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PICA <input type="checkbox"/>					PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)					S (No., Street)									
CITY					STATE									
ZIP CODE		TELEPHONE (Include Area Code)			Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code)					
( )		( )			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		( )		( )					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH				
					<input type="checkbox"/> YES <input type="checkbox"/> NO					MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH					b. AUTO ACCIDENT?					b. EMPLOYER'S NAME OR SCHOOL NAME				
MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					<input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME				
					<input type="checkbox"/> YES <input type="checkbox"/> NO									

Select the type of claim you are submitting in **Box 1**.

The correct answer is "MEDICAID".

Select the type of claim you are submitting in **Box 1**.

The correct answer is "MEDICAID".

1500														
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PICA <input type="checkbox"/>					PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)					No., Street									
CITY					STATE									
ZIP CODE		TELEPHONE (Include Area Code)			Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code)					
( )		( )			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		( )		( )					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH				
					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME				
MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					PLACE (State)									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME				
The correct answer is "90000000A95001".														

Type the recipient identification (ID) number in **Box 1a**.

The correct answer is "90000000A95001".

**1500**  
**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ ☐ PICA ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
CITY		STATE	
ZIP CODE		E (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		11. INSURED'S POLICY GROUP OR FECA NUMBER	
		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
		b. EMPLOYER'S NAME OR SCHOOL NAME	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	

Type the recipient's name in **Box 2** (use last name, first name, middle initial format). Do not use commas.

The correct answer is "Miller Joseph A".

Type the recipient's name in **Box 2** (use last name, first name, middle initial format). Do not use commas.

The correct answer is "Miller Joseph A".

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HEALTH INSURANCE CLAIM FORM									
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PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)									
6. PATIENT'S RELATIONSHIP TO INSURED Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> STATUS Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street)									
8. INSURED'S CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME									
c. INSURANCE PLAN NAME OR PROGRAM NAME									

**Tip:** Remember to put spaces between the month, day and year so each is in its designated field.  
The correct answer is "06 13 76".

Type the recipient's date of birth in **Box 3** (use MM DD YY format).

**Tip:** Remember to put spaces between the month, day and year so each is in its designated field.

The correct answer is "06 13 76".

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HEALTH INSURANCE CLAIM FORM									
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<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA         </div> <div> <input type="checkbox"/> PICA         </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div>           1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>  <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small> </div> <div>           1a. INSURED'S I.D. NUMBER  <small>(For Program in Item 1)</small>            90000000A95001         </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div>           2. PATIENT'S NAME (Last Name, First Name, Middle Initial)            Miller Joseph A         </div> <div>           3. PATIENT'S BIRTH DATE            MM DD YY            06 13 76         </div> <div>           SEX            M <input checked="" type="checkbox"/> F <input type="checkbox"/> </div> <div>           4. INSURED'S NAME (Last Name, First Name, Middle Initial)         </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div>           5. PATIENT'S ADDRESS (No., Street)             CITY             ZIP CODE         </div> <div>           6. PATIENT RELATIONSHIP TO INSURED            Other <input type="checkbox"/>            Other <input type="checkbox"/>            Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> </div> <div>           7. INSURED'S ADDRESS (No., Street)             CITY             ZIP CODE         </div> <div>           STATE             TELEPHONE (Include Area Code)            ( )         </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div>           9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)             a. OTHER INSURED'S POLICY OR GROUP NUMBER             b. OTHER INSURED'S DATE OF BIRTH            MM DD YY            SEX            M <input type="checkbox"/> F <input type="checkbox"/> </div> <div>           10. IS PATIENT'S CONDITION RELATED TO:            a. EMPLOYMENT? (Current or Previous)  <input type="checkbox"/> YES <input type="checkbox"/> NO            b. AUTO ACCIDENT?  <input type="checkbox"/> YES <input type="checkbox"/> NO            c. OTHER ACCIDENT?  <input type="checkbox"/> YES <input type="checkbox"/> NO         </div> <div>           11. INSURED'S POLICY GROUP OR FECA NUMBER             a. INSURED'S DATE OF BIRTH            MM DD YY            SEX            M <input type="checkbox"/> F <input type="checkbox"/> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div>           c. EMPLOYER'S NAME OR SCHOOL NAME         </div> <div>           b. EMPLOYER'S NAME OR SCHOOL NAME         </div> <div>           c. INSURANCE PLAN NAME OR PROGRAM NAME         </div> </div>									

The correct answer is "M".

Select **M** or **F** in **Box 3** as appropriate to the recipient's gender.

The correct answer is "M".

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**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM ADJUSTERS ASSOCIATION

PICA ☐

1. MEDICARE ☐ MEDICAID ☒ (Medicare #) (Medicaid #) (State)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
Miller Joseph A

3. DATE OF BIRTH 05 13 78 M ☒ F ☐

4. SEX

5. PATIENT'S ADDRESS (No., Street)  
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED  
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)  
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. PATIENT STATUS  
Single ☐ Married ☐ Other ☐  
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  
a. OTHER INSURED'S POLICY OR GROUP NUMBER  
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐  
c. EMPLOYER'S NAME OR SCHOOL NAME

10. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (Current or Previous)  
☐ YES ☐ NO  
b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)  
c. OTHER ACCIDENT? ☐ YES ☐ NO

11. INSURED'S POLICY GROUP OR FECA NUMBER  
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐  
b. EMPLOYER'S NAME OR SCHOOL NAME  
c. INSURANCE PLAN NAME OR PROGRAM NAME

PICA ☐ (For Program in Item 1)

CARRIER

PATIENT AND INSURED INFORMATION

Type the recipient's complete street address and telephone number in **Box 5**.

\*\* Press **Enter** after each entry to continue to the next field.

The correct answer is "1445 Millers Road".

Type the recipient's complete street address and telephone number in **Box 5**.

\*\* Press **Enter** after each entry to continue to the next field.

The correct answer is "1445 Millers Road".



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PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90000000A95001					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Miller Joseph A				3. PATIENT'S BIRTH DATE MM DD YY 06 13 78		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 1445 Millers Road				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE	
ZIP CODE		TELEPHONE (Include Area Code) ( )		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			

The correct answer is "Anytown".

The correct answer is "Anytown".



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PICA <input type="checkbox"/> <input type="checkbox"/>									
PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)									
Miller Joseph A									
3. PATIENT'S BIRTH DATE									
06   13   78 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
90000000A95001									
5. PATIENT'S ADDRESS (No., Street)									
1445 Millers Road									
6. PATIENT RELATIONSHIP TO INSURED									
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street)									
CITY									
Anytown									
STATE									
ZIP CODE									
TELEPHONE (Include Area Code)									
( )									
8. PATIENT STATUS									
Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO:									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER									
a. EMPLOYMENT? (Current or Previous)									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
b. AUTO ACCIDENT? PLACE (State)									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. INSURED'S DATE OF BIRTH									
MM   DD   YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME									
c. INSURANCE PLAN NAME OR PROGRAM NAME									

The correct answer is "CA".

The correct answer is "CA".

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PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90000000A95001					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Miller Joseph A				3. PATIENT'S BIRTH DATE MM DD YY 06 13 78		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 1445 Millers Road				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY Anytown		STATE CA		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE	
ZIP CODE		TELEPHONE (Include Area Code) ( )		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			

The correct answer is "95823".

The correct answer is "95823".

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PICA <input type="checkbox"/> <input type="checkbox"/>									
PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>									
1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
90000000A95001									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)									
Miller Joseph A									
3. PATIENT'S BIRTH DATE									
MM DD YY 06 13 78 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)									
1445 Millers Road									
6. PATIENT RELATIONSHIP TO INSURED									
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street)									
8. PATIENT STATUS									
Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO:									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER									
a. EMPLOYMENT? (Current or Previous)									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)									
b. INSURED'S DATE OF BIRTH									
MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME									
c. INSURANCE PLAN NAME OR PROGRAM NAME									

The correct answer is "916-555-4567".

The correct answer is "916-555-4567".